TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Thomas Castoldi, D.O.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-3342-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 8, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Texas Mutual on March 20, 2015 this request was in response to a $150.00 reduction of the $650.00 for the Designated Doctor Exam performed on October 4, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor placed the claimant in DRE category III. For this reason, according to Rule 134.204(j)(4)(C)(ii)(I), Texas Mutual paid the requestor $150.00 for the DRE model found in the AMA Guides 4th edition…

Further, the requestor did not document performing a full physical evaluation. He evaluated the spine and the lower extremities only with corresponding range of motion studies…"

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 4, 2014	Designated Doctor Examination (MMI/IR)	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out fee guidelines for Workers' Compensation specific services.

1. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
2. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
3. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-P12 – Workers Compensation Jurisdictional Fee Schedule Adjustment
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - CAC-18 – Exact duplicate claim/service.
   - CAC-29 – The time limit for filing has expired.
   - 224 – Duplicate charge.
   - 731 – Per 133.20(B) Provider shall not submit a medical bill later than the 95th day after the date the service.

Issues

1. Did the requestor forfeit the right to reimbursement for the services in dispute for failure to timely file a medical bill?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason codes, "CAC-29 – The time limit for filing has expired," and "731 – Per 133.20(B) Provider shall not submit a medical bill later than the 95th day after the date the service." 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Further, 2. Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   28 Texas Administrative Code §102.4 (h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission." Review of the submitted documentation finds documentation to support that a medical bill was submitted to the insurance carrier on October 14, 2014. Consequently, the requestor did not forfeit the right to reimbursement for the services in dispute for failure to timely file a medical bill.

2. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation… (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." The submitted documentation indicates that the Designated Doctor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the lumbar spine. Therefore, the correct MAR for this examination is $300.00.

3. The total allowable for the disputed services is $650.00. The insurance carrier paid $500.00. Therefore, additional reimbursement in the amount of $150.00 is recommended.

Conclusion

This decision is based upon a review of all the evidence presented by the parties in this dispute. Even though all the evidence was not discussed, it was considered. For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	June 30, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.